# LTC+: STRENGTHENING THE PARTNERSHIP BETWEEN ACUTE CARE AND LONG-TERM CARE HOMES (LTCHS)

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Humber River Health Lighting New Ways in Healthcare™

## DESCRIPTION

LTC+ is a platform that provides virtual supports to LTCHs via a Nurse Navigator following intake and triage to community and hospital services and/or telephone consultations. LTC+ aims to deliver excellent care to providers and residents in LTCHs to avoid preventable transfers to hospital and improve access to clinics/ resources. Initially launched in April 2020, LTC+ was leveraged to deliver remote monitoring to LTCHs that included implementation of a clinical deterioration tool PREVIEW-ED©, to systematically detect early signs of decline in LTCH residents. Those with deteriorating status are connected with LTC+ to provide rapid access to hospital resources and specialist consultations.

## OBJECTIVE

To reduce avoidable hospital visits, enhance LTCH staff experience and capacity, and improve resident care.

## ACTIONS TAKEN

Refresh and engagement for HRH LTC+ occurred as part of the LTC Remote Monitoring initiative in February 2021. Seven affiliated LTCHs attended biweekly meetings prior to and after the launch, where quantitative and qualitative data was shared and reviewed. This practice has been spread and sustained, with a total of 11 LTCHs connected to LTC+. Monthly meetings discuss new initiatives and reminders of existing pathways, supporting the Quintuple aim of healthcare: enhanced resident experience, health equity, cost-effective care, improved population health, and improved provider experience.

## LESSONS LEARNED

The HRH LTC+ program has been able to successfully support a growing LTCH community by connecting LTC residents to acute and primary care providers.

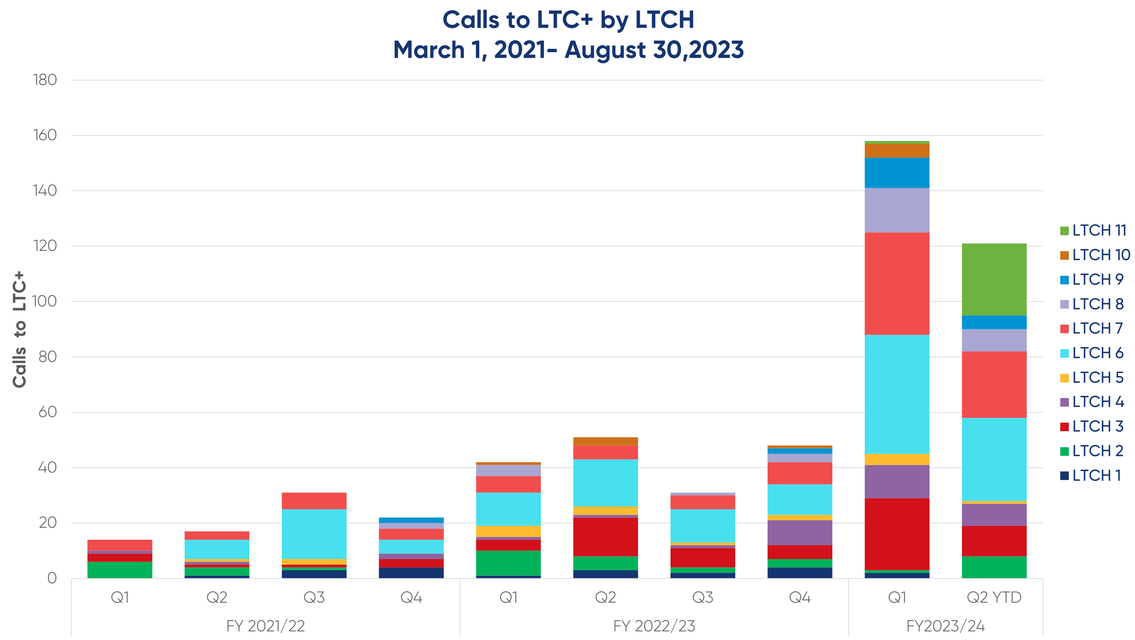


Figure 1.

Calls to LTC+ by LTCH. Since the launch of LTC+, there was an increase in calls from LTCH accessing LTC+.

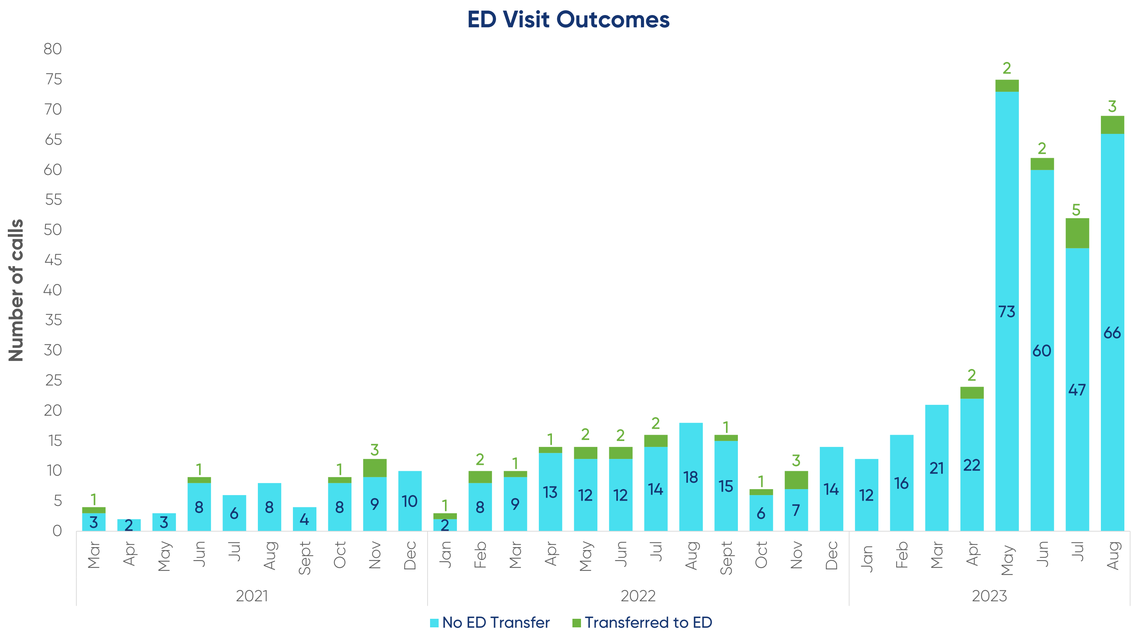


Figure 2.

ED Visit outcomes of Calls to LTC. As a result of LTC+ consults, there was a evident decline in the ED transfers from LTCH.

## SUMMARY OF RESULTS

From March 2021 to August 2023, a total of 539 calls have been made to LTC+ by affiliated LTCHs, with 93% resulting in ED diversion. The Nurse Navigation services are most often used, followed by General Internal Medicine and Geriatrician team consults (84% and 4% of calls, respectively). In addition, LTC+ pathways to Diagnostic Imaging, fracture clinic, and lower limb preservation have been successfully implemented, ensuring timely access to needed services for LTCH residents.